DORCHESTER SCHOOL DISTRICT TWO
Division of Nursing Services

HEALTH CARE PRACTIONER AUTHORIZATION FOR STUDENT SELF-MONITORING AND/OR SELF-ADMINSTRATION OF A PRESCRIBED MEDICATION FOR A MEDICAL CONDITION.

I hereby authorize student, ______________________, to self-monitor and/or self-administer a prescribed medication in accordance with the following order(s):______________

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I verify that this student's medical condition is such that self-monitoring and/or self-administration of a prescribed medication for this condition at school, on school grounds, at school-sponsored activities, or during before-school or after-school activities on school-operated properties is appropriate.

I further verify that the student has been trained and has demonstrated competency in self-monitoring and/or self-administration of a prescribed medication for this condition.

Student's Name: ______________________________ D.O. B. ____________
Last First Middle

Diagnosis for which self-monitoring of a medical condition or self-administration of a prescribed medication is needed:______________________________

____

Name of Medicine:______________________________
Form:______________________________
Dose:______________________________

If medication taken "DAILY", at what time?______________________

If medication taken "WHEN NEEDED", describe indications:______________________________

____

List side effects:______________________________

Length of time treatment is recommended:______________________________

Other information:______________________________

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Signature of Health Care Provider	Date
Street Address	Phone Number
City, State, Zip Code	Fax Number

DD2 – 817

2.432